VOLUME - 04 | ISSUE - 11 DECEMBER 15, 2020

URGENT CARING

COLLEGE OF URGENT CARE MEDICINE

OFFICIAL NEWSLETTER OF THE COLLEGE OF URGENT CARE MEDICINE

CUCM PRESIDENT - Jasmeet Bhogal, MD

Thank you:

2020 has been a year of struggle for the entire world. Yet, it has also been a year of some of the greatest stories of commitment, perseverance and kindness. Whenever there is a talk about the heroes of 2020, urgent care will always hold a special place in that story. Urgent care providers and centers across this great nation of ours have stepped up to the task and given their best in order to take care of patients during the COVID-19 pandemic. We continue to provide this care. We answered the national call to action and delivered the best we had to offer. Thank you all for all that each one of you has done this year to help your patients. You have been true warriors of this pandemic.

When we were hit by the COVID-19 pandemic, one of the initial responses from the College was the establishment of the COVID-19 Taskforce. The Taskforce was formed with a vision of serving the urgent care community by keeping everyone up to date with the latest information so that appropriate patient care and business decisions could be made, considering the ever-evolving situation as it relates to COVID-19. The Taskforce has done a great job of providing resources for urgent care providers and continues to work on COVID-19 related issues and develop more programs that will be helpful for our members.

Some of the accomplishments of the Taskforce include:

1. Initiating a COVID-19 specific Listserv: This has perhaps been the most important achievement for the Taskforce. The urgent care community has been very active on this Listserv and it has been refreshing and encouraging to see everyone asking questions and sharing ideas on the Listserv.
2. Survey: The Taskforce has worked diligently to provide an ongoing survey which providers UCA and CUCM members with the latest information on how urgent care is performing nationally when it comes to issues such as PPE supplies, patient volumes, reimbursement trends, etc. It is an extremely useful survey that the urgent care community continues to participate in and provide valuable information which is in turn shared with you all.
3. Town Halls: The Taskforce has also organized and conducted townhalls that have provided up-to-date information regarding topics related to COVID-19. The Taskforce started with the initial townhall that focused on the clinical presentation of COVID-19, moved on to lab tests available for COVID-19 testing, and added other topics. The Taskforce continues to develop townhalls with topics that are relevant in the current environment.

As the role of the Taskforce has evolved, we have realized the potential of having this taskforce and the immense benefits that it brings to our urgent care providers and the community in general. While COVID-19 continues to be the central topic in most discussions, the College also realizes that we need to keep our focus on other topics that are relevant to us and our patients. We believe that the Taskforce can take on additional responsibilities which include focusing on other clinical topics that also bring patients into our urgent care centers.

With this in mind, we are happy to announce that the COVID-19 Taskforce will be taking up additional responsibilities and will be renamed as the CUCM Clinical Response Taskforce. The Taskforce typically meets every Friday or every other Friday, depending on the need. As relevant clinical topics, COVID or non-COVID, come up, we will seek help from our members and other by requesting participation in the Taskforce based on your areas of expertise. Our vision is to have dynamic participation in this Taskforce so that we can bring the best talent together to focus on a specific topic and in turn provide the urgent care community with the best of what our experts have to offer. We welcome members who are interested in participating. We would like to hear from you. If you have an interest in joining the Taskforce, please email me at **dr_jsbhogal@gmail.com.** Please include any special areas of interest/expertise that you bring with you and we would love to include you in the relevant discussions. Hope to hear from you.

Have a Happy New Year and see you all in 2021!!.....THANK YOU

EDITOR'S CORNER - Sean M McNeeley, MD, FCUCM

2020 finally comes to an end

Well we all knew it would happen. Dr. Bhogal took the entire front page, but one perk of being the editor is you can add another page all for yourself.

This year has been like no other and last month it finally happened. The surge hit most of our home states and we decided to hold the November edition of this newsletter. Not to mention this one is late as well. We apologize for the delay, but like you we were knee deep in coronavirus care. Like most of you as the year ends we take stock of what the year has been and what we are looking forward to in the upcoming year. At this time last year most of us were in the middle of a very busy influenza season and just starting to hear about a new virus across the ocean. The flu volumes continued until the bottom fell out and then across the coutry we geared up to answer a new call. Coronavirus was spreading and the term pandemic was on everyone's tongue. Like in years past urgent care regrouped. We found supplies of PPE and tests and headed back to do our share. The days quickly became an exercise in finding the very sick among those less so, and our regular patients stayed home. The first surge came and we flattened the curve. The second wave now seems to be fading in some areas. Two vaccines have been approved and are being given across the country. We worked hard. We learned alot, but there is still a ways to go before this pandemic allows life to return to normal.

2021 what lies ahead

The vaccines will take time to produce and distribute. None of them are 100%, but every bit will help. In a few months we will all get immunized and care for those who continue to be at risk. Lookling for that needle in the haystack based on historical risk and abnormal vitals as well as other ominous signs will continue to be important. Eventually this will likely slow down and urgent care will need to focus on the next chapter. This task will involve getting our previous patients back and convincing people that care in person is essential and waiting is not. Customer service and the patient experience will be again on top of the reasons to continue visiting our locations. New loyalties caused by our presence, ability to test and perhaps vaccine provision will start us off, but expectations will continue to be high as the number of locations exceeds the volume of patients seeking care. Quality will always be important, however it will fall back to an expectation.

The College will be here as it has been during this pandemic to assist our providers and staff in caring for patients as well as providing best practices to be efficient, and assure experience expectations while continuing to be a high quality lower cost option. The new taskforce will continue to react quickly.

To do this we need your help. Please reach out to me or Dr. Bhogal with your questions, concerns, challenges and to get involved. Together we will get through this pandemic and build the next version of urgent care.

Contact Dr.McNeeley: sean.mcneeley@uhhospitals.org

CME info starts here

Let's Not Forget Measles

Joseph Toscano, MD

So far this year worldwide death rates for measles have fallen, though last year, they were the highest in recent years, and in the US, though there were no deaths, the case rate in 2019 was the highest since 1992. This year's morbidity and mortality data look better, but WHO and CDC have reported that the COVID-19 pandemic has led to lower vaccination rates (https://www.nytimes.com/2020/11/12/health/measles-deaths-soared-worldwide-last-year-as-vaccine-rates-stalled.html) which may lead to more patients having measles in the near future. While it may be the case that distancing and masking due to COVID-19 help reduce the impact of other infectious diseases, measles is spread in airborne fashion and is highly contagious. What does this mean for urgent care clinicians? Keep this rare but important disease on your radar for those febrile patients with rash. Vaccination and travel history is key. Check out the CDC's health care provider link for measles (https://www.cdc.gov/measles/hcp/index.html).

Pearls from a Practicing Pediatrician – "Influenza 2020 and Children – Latest Recommendations and a Look Back at 2019"

Thomas W. Tryon, MD, MBA, FAAP, FCUCM; UCA Pediatric Section Chair

Winter is here in and along with the winter comes Influenza season. This year will likely be one of the most challenging in my almost 30 years in healthcare as we are still dealing with COVID-19 and its implication on the health of children and the population in general. To help us prepare for the upcoming influenza season, the American Academy of Pediatrics and the Centers for Disease Control have published updates and recommendations specifically impacting children. According to the AAP Committee on Infectious Diseases "Policy Statement on Recommendations for Prevention and Control of Influenza in Children, 2020-2021" published in the Journal Pediatrics in October, 2020.[1]

1. The composition of the influenza vaccines for 2020–2021 has been updated. The recommended influenza A(H1N1)pdm09 and A(H3N2) components and the influenza B/Victoria component of the vaccine are new for this season. The B/Yamagata component is unchanged from the previous season. All quadrivalent influenza vaccines include these 4 components. The trivalent vaccines do not include influenza B/Yamagata
2. All pediatric vaccines are quadrivalent. There are no trivalent vaccines available for children.
3. Influenza vaccination is particularly important during the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pandemic to reduce the burden of respiratory illnesses and hospitalizations and preserve the capacity of the health care infrastructure.
4. Children consistently have the highest attack rates of influenza in the community during seasonal influenza epidemics. They play a pivotal role in the transmission of influenza virus infection to household and other close contacts and can experience substantial morbidity, including severe or fatal complications from influenza infection.
5. Children younger than 5 years, especially those younger than 2 years, and children with certain underlying medical conditions are at increased risk of hospitalization and complications attributable to influenza.
6. School-aged children bear a large influenza disease burden and are more likely to seek influenza-related medical care compared with healthy adults.

New treatment recommendations from the American Academy of Pediatrics state: "Antivirals are recommended for children with suspected or confirmed influenza who are hospitalized, have severe or progressive disease, or have underlying conditions that increase their risk of complications. Recent observational studies suggest antivirals can reduce the risk of certain flu complications, including hospitalization and death. Antiviral treatment also can be considered for any previously healthy, symptomatic outpatient not at high risk for influenza who 1) is confirmed or suspected of having flu, or 2) is a child whose siblings or household contacts are younger than 6 months or have a high-risk condition predisposing them to influenza complications, and 3) treatment can be started within 48 hours of illness onset."[2] I often find that the focus is more on whether treatment can be started within 48 hours than on determining if there are high-risk household contacts who may benefit from treatment of a child with known or suspected influenza. Additionally, querying the family about possible high-risk contacts at home may determine whether you can make and document a recommendation for the high-risk individual to contact their healthcare provider about possible influenza prophylaxis.

As front-line providers, we often treat patients and parents who are not vaccinated against influenza and find when talking with parents they have a sense that influenza is not a serious or worrisome disease. Looking back at the 2019-2020 season, here is what we know about influenza's impact on adults and children:

1. CDC estimates that the burden of illness during the 2019–2020 season was moderate with an estimated 38 million people sick with flu, 18 million visits to a health care provider for flu, 400,000 hospitalizations for flu, and 22,000 flu deaths. The CDC estimates include 12.5 million children under the age of 18 who were infected with influenza.
2. The CDC reports that there were 188 confirmed deaths in children under the age of 18 due to influenza. However, they believe that number is under-reported and mathematical models place the number at closer to 434. Additionally, over 7,700 working age adults (between 18-65) died from influenza this past season.[3]
3. More then 52,000 hospitalizations occurred in children under 18 years of age.

(Continued on Next Page)

(continued from page 3)

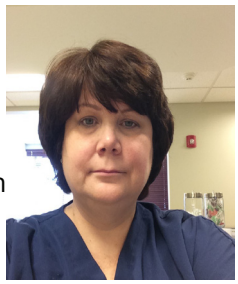
4. The 2019–2020 season was of moderate severity, although 3 peaks of influenza-like illness activity and the highest hospitalization rates in children, 68.2 per 100 000 population overall, were reported this season. The influenza peaks occurred in January, February and March, with the March influenza peak then co-existing with the SARS-CoV2 pandemic.

What about influenza treatment for 2020-2021? Treatment recommendations from the CDC website: (www.cdc.gov/flu/professionals/antivirals/index.htm) and include the use of neuraminidase inhibitors such as oseltamivir, peramivir and zanamivir and a newer medication baloxavir which is a selective inhibitor of influenza cap-dependent endonuclease. All of these medications have activity against both influenza A and B.

Last, to say this will be a challenging winter season both in the care and treatment of children and adults is an understatement. I am sure we will forever look back on 2020 as one of the more formidable winters in each of our careers. From my executive MBA training, one of my favorite leadership articles that I believe is worthwhile to read is "Leadership in Permanent Crisis" (https://hbr.org/2009/07/leadership-in-a-permanent-crisis) by Heifetz, Grashow and Linsky. While they recommend embracing disequilibrium, fostering adaptation and embracing leadership, they also make an important point that as a leader, it is important for you to take care of yourself. We all lose the opportunity to care for patients and lead in our practices if we ourselves become ill or incapacitated. One of their recommendations is for each of us to find sanctuaries where we can reflect on the challenges we are facing. My hope for you is that you will find that sanctuary and stay safe and well.

1 https://pediatrics.aappublications.org/content/pediatrics/146/4/e2020024588.full.pdf
2 https://www.aappublications.org/news/2020/09/08/flupolicy090820
3 https://www.cdc.gov/mmwr/volumes/69/rr/pdfs/rr6908a1-H.pdf

COVID-19 and Aberrancies of Smell and Taste



Tracey Q. Davidoff, MD, FCUCM

I have been avoiding writing "In the News" articles, because let's face it, the only thing we care about that's in the news right now in medicine is related to COVID-19. We get way too much of that on a daily basis, so the last thing I wanted to do was add more. However, after having COVID-19 personally, and after losing much of my smell and taste, I set out to research why this happens, what it means, and will it ever come back.

I first noticed anosmia on day 3-4 of my illness when I was cooking bacon. My daughter, who was in her room grudgingly under quarantine as an exposed person, stuck her head out and said, "wow, that smells good. Are you cooking bacon?" I suddenly realized I was incapable of smelling the bacon! I grabbed a variety of pungent objects from my kitchen such as cloves, onions, garlic, and cinnamon, and nothing. Couldn't smell a darn thing. I even tried the pepper shaker. Oddly it made me sneeze, but I couldn't smell it. In retrospect, for the last few days, foods were tasting very bland. I have always been more of a tactile eater than a taste eater, so the taste piece was not really bothersome, but still, it was strange. I started adding hot sauce to my food. Something I would never have done pre-COVID.

Fast-forward almost 7 months, and I still can't smell much. Definitely better, but not much. I did not realize how much we rely on smell. Twice now I have eaten expired dairy products and gotten sick because it didn't smell (or apparently taste) bad. I can't smell when the garbage needs to go out, so it goes out twice a day. I'm having a great deal of difficulty smelling bodily smells. That leads to deodorant twice a day, washing clothing after minimal use, and brushing my teeth more frequently. Air freshener in the bathroom after every use. At work, this is a good and a bad thing. I cannot smell melena, abscesses, body odor, or BV. Normally, I can recognize the sweet smell of DKA. Nada. Makes work more pleasurable, but I feel like one of my tools has gone missing. Recently I have been smelling things burning. Just a whiff, then gone. My staff thinks I'm crazy when I go around sniffing and asking if anyone smells anything burning. This occurs daily. I'm sure I can't smell gas. Thank goodness nothing in my home is powered by it

So what do I do? What I always do when I confront a medical problem I don't know much about. I search Uptodate, Google Scholar, and OK, you caught me, regular Google to find some answers. And since I'm researching it anyway, I'll share it with you, our loyal Urgent Caring readers.

(CME Continues on page 5)

(continued from page 4)

The CDC reports that up to 80% of patients who have confirmed COVID-19 infections will experience some aberration of taste or smell. 3% of COVID-19 patients will have disturbance of taste of smell as their ONLY symptoms. 89% of patients with these symptoms will have complete recovery within 4 weeks.

MRI studies of these patients shows signal abnormalities in the olfactory bulbs that resolve on follow up. Autopsy studies show inflammatory infiltrates and axonal injury in the olfactory tracts.

Phantom smells, or phantosmia, is a condition that occurs sometimes related to the upper respiratory infection, anxiety, or idiopathically, oddly enough in middle age females (of which I am one). Most patients will smell something burning that is not present. This condition is found in a very small number of COVID-19 patients.

There has been some success of treating anosmia with "smell training". This is sort of a physical therapy for the olfactory system. Four to five scents known to the patient are sniffed several times a day for several months in the hopes of retraining the brain to smell again. Recommended scents include rose, lemon, cloves, eucalyptus, cinnamon, vanilla, orange, and banana.

Other than this, there is currently no known treatment for persistent loss of smell taste related to COVID-19. The good news is that most patients will regain their smell in less than a few weeks. Unfortunately, there are a few outliers who may have prolonged aberrations of smell that might even be permanent. There are reports that olfactory neurons can regenerate over the course of years. Fingers crossed that I'm not one of them!

References:
1. https://www.uptodate.com/contents/coronavirus-disease-2019-covid-19-neurologic-complications-and-management-of-neurologic-conditions?search=covid%2019%20smell&source=search_result&selectedTitle=3~150&usage_type=default&display_rank=3#H2406785297, accessed online 10/10/2020
2. https://www.uptodate.com/contents/evaluation-and-treatment-of-taste-and-smell-disorders?search=covid%2019%20smell&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2, accessed online 10/14/2020
3. Parma V, Ohla K, et. al. More than smell-COVID-19 is associated with severe impairment of smell, taste, and chemesthesis, *Chemical Senses, 45:7*. Sept 2020. https://academic.oup.com/chemse/article/45/7/609/5860460, accessed online 10/17/2020

Allergic Reactions

Sean M McNeeley, MD, FCUCM

As we note one of the most worrisome side effects of the new vaccines is allergic reactions, it is important to have a process to treat these commited to memory. All things considered the most important and best proven treatment is epinephrine 0.01mg/kg. Adult doses usually stop at 0.3mg. The pre-made pens come in 0.15mg and 0.3mg. They are expensive but nice to have. The other doses come in a glass vial that needs to be broken, drawn up with a filter needle and given IM in thigh or deltoid muscles. Below is a good reminder of comprehensive allery treatment:

Acute Allergic Reaction Guidelines

A) Call for help (provider must order any medications/treatments)
B) ABC's
C) Epinephrine 1:1000 (Preferred Route = IM, Site = Vastus Lateralis) (Adult 0.3mg; Child 0.01mg/kg)
D) Start IV
E) Consider Normal Saline
F) Diphenhydramine IV (Adult 25-50mg/Child 1mg/kg)
G) H-2 blocker
H) Albuterol aerosols inhalation (particularly in asthmatics)
I) Oxygen
J) Methylprednisolone IV (Adult 125mg/Child 1-2mg/kg)

(This information represents the most common treatment of acute allergic reaction and does not take the place of a provider's judgment or apply to all patients)

Continuing Medical Education (CME)

Target Audience

This CME activity is intended for medical professionals who practice medicine in the on-demand space including urgent care, retail medicine and other similar venues. These providers may include physicians, nurse practitioners, and physician assistants.

Designation Statement

The Urgent Care Association (UCA) designates this enduring material activity for a maximum of *1 AMA PRA Category 1 Credit(s)* ™. Physicians should claim credits only commensurate with the extent of their participation in the activity. Credits may be claimed for one year from the date of release of this issue.

CME Objectives

1. **Provide updates on the diagnosis and treatment of clinical conditions commonly managed by on-demand providers**
2. **Alert on-demand providers to potential unusual cases that may present to them**
3. **Utilize tips and tricks to improve patient care in the on-demand space**

Accreditation Statement

This activity has been planned and implemented in accordance with the accreditation requirement and policies of the Accreditation Council for Continuing Medical Education (ACCME) though the joint providership of the Urgent Care Association and the College of Urgent Care Medicine. UCA is accredited by the ACCME to provide continuing medical education for physicians.

CME Credit Instructions

Once you have read the article, please log into your UCA profile. Once you are logged in go to *Manage My Account -> My Library*. Now you will be logged into the UCA Online Education Library.
Go to *Course Catalog -> Clinical -> Urgent Caring CME*. Click on the Urgent Caring edition for this month.
You will need to score 60% on the Quiz and complete the Survey to obtain credit.
Your certificate will show up under *My Library -> Credits*.
Please email education@ucaoa.org with questions.

CUCM CME Planning Committee

Jasmeet Bhogal, MD
Reports no financial interest relevant to this newsletter
Tracey Davidoff, MD, FCUCM
Reports no financial interest relevant to this newsletter
Sean M. McNeeley, MD, FCUCM
Reports no financial interest relevant to this newsletter
Joseph Toscano, MD
Reports no financial interest relevant to this newsletter

Authors

Jasmeet Bhogal, MD
Reports no financial interest relevant to this newsletter
Tracey Davidoff, MD, FCUCM
Reports no financial interest relevant to this newsletter
Sean M. McNeeley, MD, FCUCM
Reports no financial interest relevant to this newsletter

Disclaimer

Medical practice and knowledge is constantly evolving and changing. This information is peer-reviewed but should not be your only source. Providers of care should use discretion when applying knowledge to any individual patient.

CME Questions*:

1. What is the most important medication in the treatment of anaphylaxis?
a. Diphenhydramine
b. Steroids
c. Epinephrine
d Albuterol

2. Which of the follwing is a symptom of coronavirus that is rare in other viral illnesses?
a. Dizziness
b. Anosmia
c. Bodyaches
d. Fever

3. Which of the following vaccine-preventable diagnoses is making a resurgence in the US?
a. Varicella
b. Polio
c. Smallpox
d. Measles

4. Which of the following is not a suggested indication for influenza treatment in children?
a. Hospitalization
b. Significant underlying conditions
c. Prolonged symptoms
d. Severe or progressive disease

Answers from last month

1. The most important aspect of the management of warm water immersion foot and non-freezing cold injury is:
a. Treating pain with opioid pain medication
b. Preventing infection with prophylactic antibiotics
c. Initiating treatment with amitriptyline
d. Preventing reinjury
e. Actively warming with warm water baths and rubbing

2. Which of the following is true regarding exercise-induced vasculitis (EIV)?
a. Use of an oral steroid is recommended to rapidly resolve the rash
b. A diuretic such as furosemide should be used to lessen edema
c. Compression socks may prevent the rash from developing in the future
d. A skin-specific antibiotic such as cephalexin or dicloxacillin should be prescribed
e. The patient should have a CBC and a comprehensive metabolic profile as well as an ultrasound of the lower extremities to exclude systemic involvement

3. Which of the following is accurate regarding COVID-19 in children?
a. Transmission to newborns before birth is common
b. The majority of newborn cases are severe
c. All those testing positive around birth acquired it once born
d. Much is still unknown about coronavirus and pregnancy

ABOUT US

College of Urgent Care Medicine

The College of Urgent Care Medicine (CUCM), formally known as the Urgent Care College of Physicians (UCCOP), was founded by physicians from the Urgent Care Association (UCA) to provide a clinician voice for the specialty. CUCM and UCA continue to work closely to advance the clinical practice of urgent care medicine. In 2016 the UCCOP board voted to include physician assistants and nurse practitioners as members. Thus in early 2017 the decision to change our name was made.

Mission Statement

We are urgent care clinicians inspiring excellence in patient care and advancing the specialty through education, advocacy, and research.

COLLEGE OF URGENT CARE MEDICINE

28600 Bella Vista Pkwy Suite 2010
Warrenville, IL 60555

PHONE: 1 855-698-2267

eMAIL: INFO@CoUCM.ORG

@TheUC_College

Like us on FaceBook

WWW.CoUCM.ORG